

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

PERSONAL CARE SERVICES/COST REPORT
2007 Exemption Form

Due Date: JULY 25, 2008

PLEASE COMPLETE AND SUBMIT TO DMA

(Agency Name)

(Agency Address)

(Agency's Fax #)

(Agency Phone #)

(Agency Email Address)

(Medicaid Provider #s)

(NPI #)

This agency is requesting exemption for the submission of the 2007 Cost Report for the following reason(s):

- ☐ The agency received less than \$50,000 in Medicaid payments (PCS, PCS-Plus & CAP-DA revenues combined) for the 2007 reporting period.
- ☐ The agency was operative six months or less and/or has received less than \$50,000 in PCS, PCS-Plus & CAP-DA Medicaid revenues.
- ☐ Other-

(Signature of the Provider Agency)

Date

(Printed Name)

Exemption request granted - YES or NO

Signature of the DMA Analyst

Date

Mailing Address (for regular mail):
DHHS-DMA-Finance Management, Attn: Cindy Bass,
2501 Mail Service Center, Raleigh, NC 27699-2501

Office # 919-855-4214